

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? (x) Yes () No
Requestor's Name and Address Dr. B 7125 Marvin D. Love #107 Dallas, TX 75237	MDR Tracking No.: M4-03-5080-01
	TWCC No.: _____
	Injured Employee's Name: _____
Respondent's Name and Address Hartford Insurance Co. Box 27	Date of Injury: _____
	Employer's Name: _____
	Insurance Carrier's No.: YBUC 32765

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
06/05/02	06/05/02	99080-73	\$15.00	

PART III: REQUESTOR'S POSITION SUMMARY

Position Statement dated 03/06/03 states in part, "...Our charge for above date of service was denied as code F; Reimbursement for a work status report is limited to one report every two weeks. Our last report was done on 5/5/02; therefore, it has been 2weeks as required by TWCC."

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement dated 04/29/03 states in part, "...Dr. B is the treating doctor ... He filed a TWCC73 for date 6/5/02. The doctor states that a TWCC 73 had not been filed in over two(2) weeks. However, Dr. P, a doctor at the same facility and working under the direction of the treating Dr B, filed a TWCC73 to the carrier on 5/25/02... It is the responsibility of the treating doctor to coordinate and oversee the care of his patient. The TWCC73 filed by the "co-treating doctor" should be considered as filed by the treating doctor, and the time frame of filed TWCC73s was less than two weeks.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION


PART VI: DETAIL FINDINGS (If needed)

[illegible]

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$_____. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

 _____ Authorized Signature	Marguerite Foster _____ Typed Name	12/10/04 _____ Date of Order
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Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

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PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____

Signature of Insurance Carrier: _____ Date: _____